

7242

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Worcester</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		LENGTH OF STAY (in this place) <i>30 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		OR TOWN <i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
<i>Elizabeth J. Disharoon</i>				<i>July 22 1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>		8. DATE OF BIRTH: <i>July 9-1872</i>	
9. AGE last birthday <i>83</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>		11. BIRTHPLACE (State or foreign country): <i>Shawfield, Delaware</i>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME: <i>Isaac W. Busby</i>			
14. MOTHER'S MAIDEN NAME: <i>Mary J. Swift</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>None</i>				17. INFORMANT & ADDRESS: <i>My James W. Gray, Snow Hill, md</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Acute Pulmonary Edema</i>						<i>1 day</i>	
ANTECEDENT CAUSE (B) <i>Myocardial Insufficiency</i>						<i>1 month</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State)		21f. HOW DID INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <i>June</i> , 1951., to <i>July 22</i> , 1955, that I last saw the deceased alive on <i>July 22</i> , 1955, and that death occurred at <i>8 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Robert L. Palmer</i>		ADDRESS <i>Snow Hill</i>		DATE SIGNED <i>7/23/55</i>		M.D. <i>md</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>July 24/55</i>		NAME OF CEMETERY OR CREMATORY <i>Christians Cemetery</i>		LOCATION (City, town or county) (State) <i>Snow Hill md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>July 24, 55</i>		REGISTRAR'S SIGNATURE <i>Glenn E. Cooper</i>		24. FUNERAL DIRECTOR <i>Walter Williams</i>		ADDRESS <i>Snow Hill, md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

RECEIVED

AUG 16 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07237

7239

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>R.F.D. #2 Box 7</u>				X TOWN <u>R.F.D. #2 Box 7</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Home</u>				<u>Pocomoke City, Maryland</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
<u>Rosa Anderson</u>				OF DEATH: <u>July 30</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F.</u>	<u>C.</u>	<u>Married</u>	<u>April 2, 1893</u>	<u>62</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>House wife</u>				<u>Domestic</u>		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Levin Wilson</u>				<u>Susan Hargis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>None</u>			
17. INFORMANT & ADDRESS:				<u>James Anderson, Pocomoke City, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>151X</u>				<u>Exhaustion & Malnutrition</u>			
ANTECEDENT CAUSE (B)				<u>9/23/54</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>Anemia (Sec. to)</u>			
(C)				<u>to</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Gastric Cancer</u>			
<u>Generalized Arteriosclerosis</u>				<u>7/30/55</u>			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <u>9/23, 1954</u> , to <u>7/30, 1955</u> , that I last saw the deceased alive on <u>7/30, 1955</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Bevil A. Swanner</u>				DATE SIGNED <u>Pocomoke City, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. FUNERAL DIRECTOR ADDRESS			
<u>Burial</u>				<u>Edgar Whorton New Church, W.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>Aug 3, 1955</u>				REGISTRAR'S SIGNATURE <u>Anne E. White</u>			

BUREAU V. S.

AUG 5 1955

RECEIVED

7240

CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WORCESTER</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write and give nearest town)			
OR TOWN <u>BERLIN</u>		<u>39 yrs</u>		OR TOWN <u>BERLIN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>RFD LIBERTY TOWN</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Esther</u> (Middle) <u>Barbara</u> (Last) <u>Belovics</u>				DATE OF DEATH: <u>July 2</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	12. IF UNDER 36 HRS.
<u>Fe.</u>	<u>W</u>	<u>SINGLE</u>	<u>April 12, 1904</u>	<u>51</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Housewife</u>				<u>own home</u>		<u>Pennsylvania</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Alexander Belovics</u>				<u>Barbara Klinko</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give War or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>no</u>		<u>Miss Julia Belovics Berlin, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>						<u>3 weeks</u>	
ANTECEDENT CAUSE (B) <u>No known antecedent causes</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Sexual and severe catheter</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 25</u> , 19 <u>55</u> , to <u>July 2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>55</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert G. Hubbard M.D.</u>				DATE SIGNED <u>7/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>7/4/55</u>		<u>Evergreen</u>	
24. FUNERAL DIRECTOR				ADDRESS			
<u>Helen F. Hayward</u>				<u>Anna S. Burbridge Berlin Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 11 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 188230

7241

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Newark</u>		<u>80 yrs</u>		TOWN <u>Newark</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Leslie Parker Bowen</u>				<u>July 20 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>male</u>	<u>white</u>	<u>married</u>	<u>Oct. 10, 1874</u>	<u>80 yrs.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>STORE KEEPER</u>		<u>FRUIT STORE</u>		<u>Newark md</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Ira Parker Bowen</u>				<u>Susanah Bydelotte</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>220-10-8396</u>		<u>Mr. Luther Bowen, Newark Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) DUE TO <u>Congestive Heart Failure</u>						<u>?</u>	
ANTECEDENT CAUSE (B) DUE TO <u>Hypertensive Arterio-sclerotic Cardiovascular Disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/26, 1955</u> , to <u>July 21, 1955</u> , that I last saw the deceased alive on <u>July 16, 1955</u> , and that death occurred at <u>5:45 p. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas L. Jones, M.D.</u>		ADDRESS <u>Snare Hill, Md.</u>		DATE SIGNED <u>7/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/22/55</u>		<u>Garden of Memories</u>		<u>Newark md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 22, 55</u>		REGISTRAR'S SIGNATURE <u>Chas. E. Cooper</u>		24. FUNERAL DIRECTOR ADDRESS <u>Anna A. Burby, Burton Md.</u>			

BUREAU V. S.

AUG 16 1965

RECEIVED

7235

CERTIFICATE OF DEATH

Reg. Dist. No. 07240 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 42 TOWN Pocomoke City,		LENGTH OF STAY (in this place) 3 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke City, 42			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 6 Bridge Street				STREET ADDRESS (If rural give location) 1 6 Bridge Street			
3. NAME OF DECEASED: (First) (Middle) (Last) Margaret V. Dryden				4. DATE (Month) (Day) (Year) OF DEATH: July 18 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: April 23, 1873	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Henry C. Long				14. MOTHER'S MAIDEN NAME: Sarah Carey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Henry M. Dryden, Pocomoke, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 002X							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1950 19, to 7/18, 1955 that I last saw the deceased alive on 7/18, 1955 and that death occurred at 1:30 M, from the causes and on the date stated above. SIGNATURE Louis E. Flavelynn, M.D. ADDRESS Pocomoke City, DATE SIGNED 7/19/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 21, 1955		NAME OF CEMETERY OR CREMATORY Baptist Cemetary		LOCATION (City, town, or county) (State) Rehobeth, Maryland	
DATE REC'D BY LOCAL REGISTRAR July 21, 1955		REGISTRAR'S SIGNATURE Anne E. White		24. FUNERAL DIRECTOR Henry H. Watson, Pocomoke, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8

JUL 25 1955

RECEIVED

7243

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1 PLACE OF DEATH:				2 USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin		LENGTH OF STAY (in this place) Most of life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route # 3				STREET ADDRESS (If rural give location) Route # 3		X	
3. NAME OF DECEASED: (First) Nancy (Middle) Purnell (Last) Hammond		4. DATE OF DEATH: (Month) 7 (Day) 10 (Year) 1955					
5. SEX: Female		6. COLOR OR RACE: A.A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow		8. DATE OF BIRTH: 8- -1873	
9. AGE last birthday: 81 yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife		11. BIRTHPLACE (State or foreign country): Berlin, Worcester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Morris Waters		14. MOTHER'S MAIDEN NAME: Sarah Hudson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None	
17. INFORMANT & ADDRESS: Mrs. Marjorie Foreman, Berlin, Md. Rt. # 3							
18. MEDICAL CERTIFICATION				Interval Between Onset And Death			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) acute pulmonary edema				12-24 hrs			
Antecedent causes (s) (b) Congestive heart failure				72 hrs			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) Hypertensive Cardio-vascular disease				Several years			
11. OTHER SIGNIFICANT CONDITIONS				Arteriosclerosis			
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
				20. AUTOPSY?			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				21. PLACE (Home, farm, factory, street, office bldg., etc.)			
(CITY OR TOWN)				(COUNTY)			
(STATE)							
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED			
m.				While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from 5-7, 1954 , to 7-9, 1955 , that I last saw the deceased alive on 7-9, 1955 , and that death occurred at 7-10-55 , from the causes and on the date stated above.							
SIGNATURE Harry N. Shuler, Jr. (Degree or title)				DATE SIGNED 7-17-55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-13-55		Cedar Chapel Cemetery		Newark Worcester Co. Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7-13-55		Helen F. Hayward		Mary A. Stewart		324 S. Church St., Salisbury, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11-11-11

11-11-11

07243

MARYLAND

STATE DEPARTMENT OF HEALTH

7244

CERTIFICATE OF DEATH

Reg. Dist. No. 555

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ocean City</u> LENGTH OF STAY (In this place) <u>4 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ocean City</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>Rt 2 # 1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Eleanor</u> (Middle) <u>May</u> (Last) <u>Jarman</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>May 17, 1895</u>
9. AGE last birthday <u>60 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Simmamow</u>		14. MOTHER'S MAIDEN NAME <u>Virginia E. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Dr. Edward J. Jarman Ocean City Md</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
Immediate cause <u>157X</u>		(a) <u>Carcinoma of pancreas</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) <u>Diabetes mellitus</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		(c) <u>Diabetes mellitus</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan, 1955, to July 21, 1955, that I last saw the deceased alive on 21 July 1955, and that death occurred at 12:45 PM from the causes and on the date stated above.

SIGNATURE E. J. Jarman M.D. ADDRESS Ocean City, Md DATE SIGNED 23 July 55

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>7/23/55</u>	<u>Evergreen</u>	<u>Berlin</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>7-25-55</u>	<u>Helen F. Hayward</u>	<u>James A. Benbag</u>	<u>Berlin Md</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUL 27 1935

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

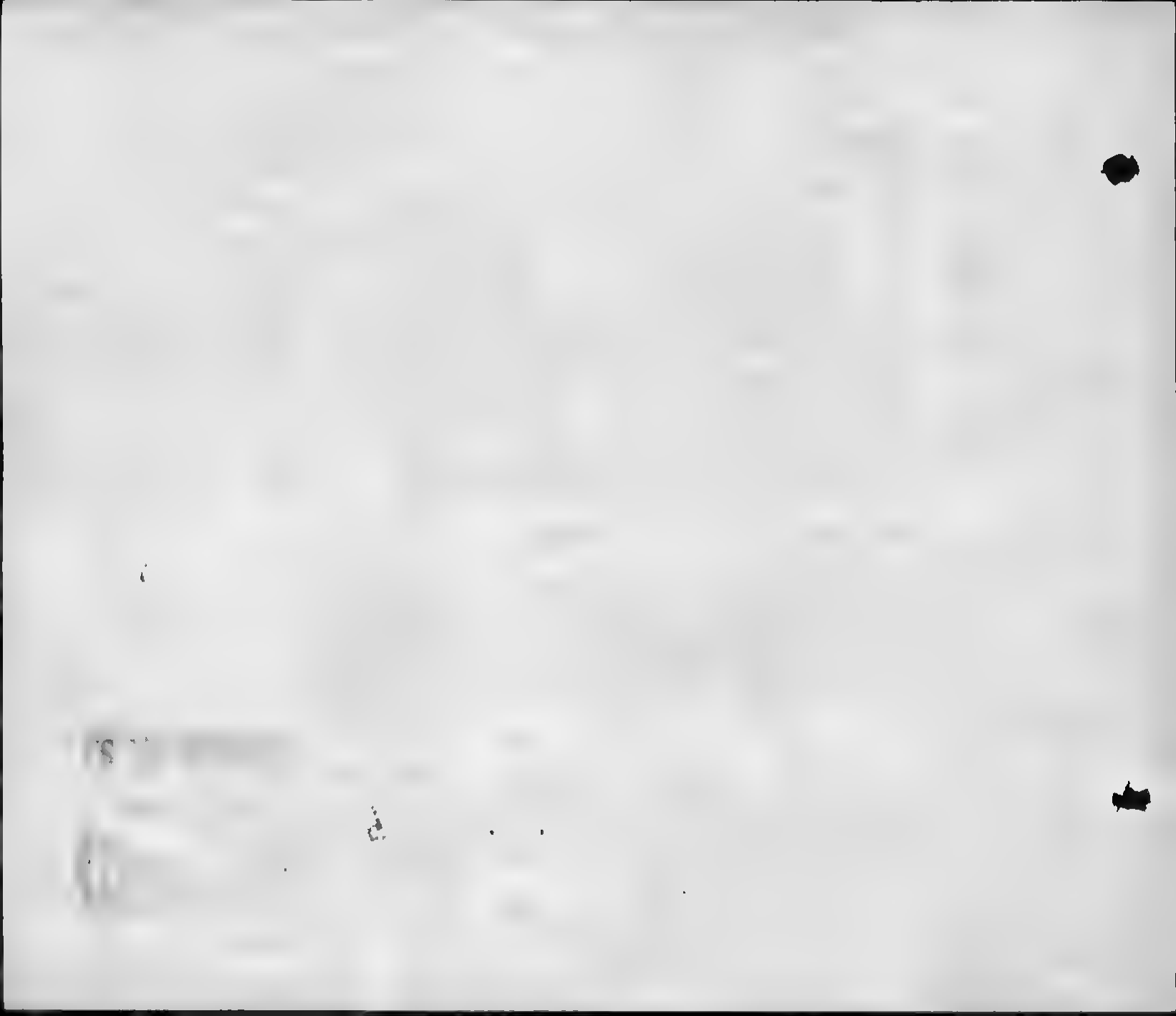
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07244

7245

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Pocomoke</u>		<u>39 years</u>		OR TOWN <u>Pocomoke</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Rural</u>				<u>Rural</u> /			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>HARRY R. LUKEHARD</u>				<u>July 15 1955</u>			
5. SEX	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>March 1, 1887</u>	<u>68 yrs</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Concrete Work</u>		<u>Virginia</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME.			
<u>James Lukehard</u>				<u>Eula Gleason</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) If Yes, give war or dates of service: <u>WW I</u>				16. SOCIAL SECURITY NO. <u>213-22-7998</u>			
17. INFORMANT & ADDRESS: <u>RFD, Lillian M. Lukehard, Pocomoke, Md.</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>2041</u> <u>Cardiac Failure</u>						<u>2-3 days</u>	
ANTECEDENT CAUSE (B) <u>Anemia, Extremely Severe</u>						<u>2 years (approx)</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Leukemia, Chronic, myeloid -</u>						<u>2 yrs (approx)</u>	
<u>Purpura Secondary to C "atue</u>						<u>2 weeks</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>U</u> ✓		19B. MAJOR FINDINGS OF OPERATION <u>✓</u>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>✓</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>14 Feb., 1955</u> , to <u>15 July, 1955</u> , that I last saw the deceased alive on <u>15 July, 1955</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. E. Sartorius, Jr.</u>		M.D. <u>Pocomoke, Md.</u>		DATE SIGNED <u>16 July 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 17, 1955</u>		<u>Baptist Cemetery</u>		<u>Pocomoke City, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 16, 1955</u>		<u>Anne E. White</u>		<u>Henry H. Watson, Pocomoke, Md.</u>			



7246

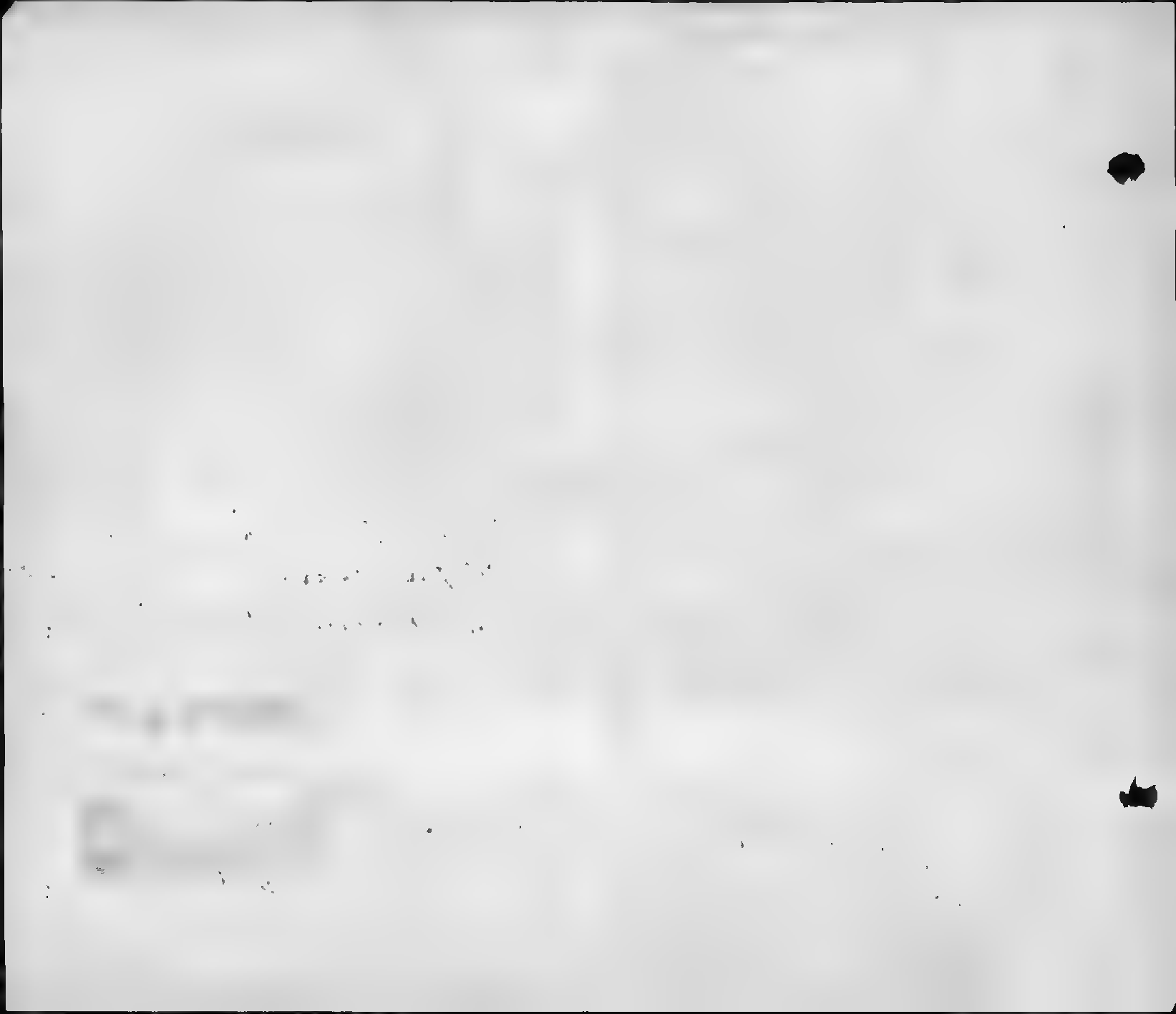
CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Pocomoke</u>		<u>79</u> Years		OR TOWN <u>Rural Pocomoke</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. No. 2</u>				STREET ADDRESS (If rural give location) <u>R.F.D. No. 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Annie F. Mason</u>				<u>July 18 19 55</u>			
5. SEX.	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH.	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>February 5, 1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country).	
<u>Housewife</u>						<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Gibbons</u>				<u>Susan Ardis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Annie Mae Phillips, Pocomoke, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE				(A) DUE TO		<u>Cardiac Failure</u>	
ANTECEDENT CAUSE (S)				(B) DUE TO		<u>Starvation</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST				(C) DUE TO		<u>Large Bowel Neoplasm Inoperable</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 30</u> , 19 <u>46</u> to <u>July 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>55</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>A. G. Sartorius, Jr.</u>				M. D. <u>Pocomoke, Md.</u>		DATE SIGNED <u>July 18 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>July 20, 1955</u>		<u>Salem M.E. Cemetery Pocomoke, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>July 19, 1955</u>				<u>Anne E. White</u>		<u>Henry H. Watson, Pocomoke, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7236

07246

Reg. Dist. No. 350

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Brown</u>	
CITY (If outside corporate limits write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Accomack City</u>		<u>June 26-55</u>		TOWN <u>Hollandale</u>		<u>48 X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lucy Cooper's home</u>				STREET ADDRESS (If rural, give location) <u>724 N.W. - 3rd Court</u>			
3. NAME OF DECEASED:		(First) <u>John</u>		(Middle) <u>Wm</u>		(Last) <u>Patton</u>	
(Type or Print)				4. DATE OF DEATH		(Month) <u>July</u> (Day) <u>23</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>June 19, 1914</u>	9. AGE last birthday: <u>41</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Nassau</u>	
13. FATHER'S NAME: <u>(D.K.)</u>				14. MOTHER'S MAIDEN NAME: <u>(?)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>267-24965</u>		17. INFORMANT & ADDRESS: <u>Lucy Cooper - Hollandale</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>			
445X Immediate cause (a)..... DUE TO <u>Cerebral Hemorrhage</u>							
Antecedent cause(s) (b)..... DUE TO <u>Hypertension</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)..... <u>Chronic Ischemic disease</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Excessive heat</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Indoor</u>		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>N. E. Victorius</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>7/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>7/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cape Henry</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
DATE REC'D BY LOCAL REG. <u>July 29, 1955</u>		REGISTRAR'S SIGNATURE <u>Anne E. White</u>		24. FUNERAL DIRECTOR <u>Edgar Anthon</u>		ADDRESS <u>One New Church St.</u>	

BUCKLE UP

3 1 1055

10-12

MARYLAND STATE DEPARTMENT OF HEALTH

07247

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 353

7247

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Beeshop</u> LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Beeshop</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Annie</u> <u>Bell</u> <u>Murray</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July</u> <u>26</u> <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan 31, 1879</u>
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>76</u> yrs. <u>1</u> Mo. <u>1</u> Day
11. BIRTHPLACE (State or foreign country) <u>Worcester Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William B Beauchamp</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Godfrey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hazel Stirlitz, Wilmington</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>9</u> about <u>5</u> years
Immediate cause <u>443x</u> (a) <u>hypertensive, arteriovascular</u>		
Antecedent cause(s) <u>cardiovascular disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>cardiac decompensation</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1954, to July, 1955, that I last saw the deceased alive on 6 Aug, 1955, and that death occurred at 9:20 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>July 29, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>	LOCATION (City, town, or county) <u>Beeshopville, Del.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>July 28-55</u>	REGISTRAR'S SIGNATURE <u>Mrs. Hilda Berges</u>	24. FUNERAL DIRECTOR <u>Henry N. Watson, Pocomoke City, Md.</u>		ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU W. T.

JUL 23 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 355

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>New Jersey</u>	COUNTY <u>Cape May</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Ocean City</u>	LENGTH OF STAY (In this place) <u>4</u> hours	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Ocean City</u>	<u>37 x - 3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beach at Dorchester St</u>		STREET ADDRESS (If rural, give location) <u>5737 Astbury Ave</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>FRANK</u> (Middle) <u>BOONE</u> (Last) <u>Myers</u>		(Month) <u>JULY</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec 5 1988</u>
9. AGE last birthday: <u>66</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Ridley Park Pa</u>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Builder</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>George Myers</u>		14. MOTHER'S MAIDEN NAME: <u>See Harper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u> (If yes, give war or dates of service) <u>✓</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Betty See Myers Ocean City, N.J.</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

2 minutes

21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>H. J. [Signature]</u> CHIEF MEDICAL EXAMINER DATE SIGNED <u>July 12 55</u> M. D. DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>7/15/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Delaware Cr. Co. Pa.</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE: <u>7/12-55</u>	24. FUNERAL DIRECTOR: <u>Helen F Hayward</u>	ADDRESS: <u>Delaware Cr. Co. Pa.</u>



7249

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. **353**

1. PLACE OF DEATH - COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook, Del.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook, Del. (Rural)</u>	
TOWN <u>Seabrook, Del.</u>		TOWN <u>Seabrook, Del. (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>X</u>	
3. NAME OF DECEASED (Type or Print) <u>Leo</u> (First) <u>Strassen</u> (Middle) <u></u> (Last)		4. DATE OF DEATH <u>July 30</u> (Month) <u>30</u> (Day) <u>1955</u> (Year)	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>1885</u>
9. AGE last birthday <u>70</u> yrs.		10. If under 1 year: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>See Deceased</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Edmer Hall, Seabrook, Del.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) <u>Coronary thrombosis, acute,</u>		<u>minutes</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Plummer's, and Coronary Heart Disease</u>		<u>4-5 yrs</u>
(c) <u>Atherosclerosis, Bicuspid</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) <u>Bethesda, R.F.D. #1</u> (COUNTY) <u>Montgomery</u> (STATE) <u>MD</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE Edmer Hall (Degree or title) Med. Ex. ADDRESS Bethesda, Md. DATE SIGNED 8/1/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Aug. 1, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Bethesda</u>	LOCATION (City, town, or county) (State) <u>Bethesda, Md.</u>
DATE REC'D BY LOCAL REG. <u>Aug. 1, 1955</u>	REGISTRAR'S SIGNATURE <u>Edmer Hall</u>	24. FUNERAL DIRECTOR <u>Henry J. Watson</u>	ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

• 9. 1950/51

100

7250

07250

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

Item 21

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 350

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
<u>Pocomoke Md (Rural)</u>	<u>years</u>	<u>Pocomoke (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
		<u>Back yard</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Leonard Clifford Sturgis</u>		<u>July 10 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>	8. DATE OF BIRTH: <u>7/4/55</u>
		9. AGE last birthday: (If under 1 year) (Months) (Days) (Hours) (Min.)	
		<u>6 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>Infant</u>	<u>None</u>	<u>Md</u>	
13. FATHER'S NAME: <u>Lester Deuhl</u>		14. MOTHER'S MAIDEN NAME: <u>Vergie Sturgis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or rank.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Vergie Sturgis Mother</u>	
<u>No</u>			
16. SOCIAL SECURITY No.: <u>-</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a).....		<u>rotally accidental</u>	
DUE TO			
Antecedent cause(s) (b).....			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c).....			
<u>Asphyxia</u>			
<u>Strangulation</u>			
<u>Smothered</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	21c. (City or town) (County) (State)	
	<u>Pocomoke City</u>	<u>Worcester</u>	<u>Md.</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 9th to 10th M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Child found over covered in a hot stuff, room</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>V.E. Antonis</u>		M. D. <u>7/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>7/10/55</u>	NAME OF CEMETERY OR CREMATORY <u>Worcester Cem</u>	LOCATION (City, town, or county) (State) <u>Pocomoke, Md</u>
DATE REC'D BY LOCAL REG. <u>July 13, 1955</u>	REGISTRAR'S SIGNATURE <u>Anne E. White</u>	24. FUNERAL DIRECTOR <u>Edgar Roberts</u>	
		ADDRESS <u>New Church, 20</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

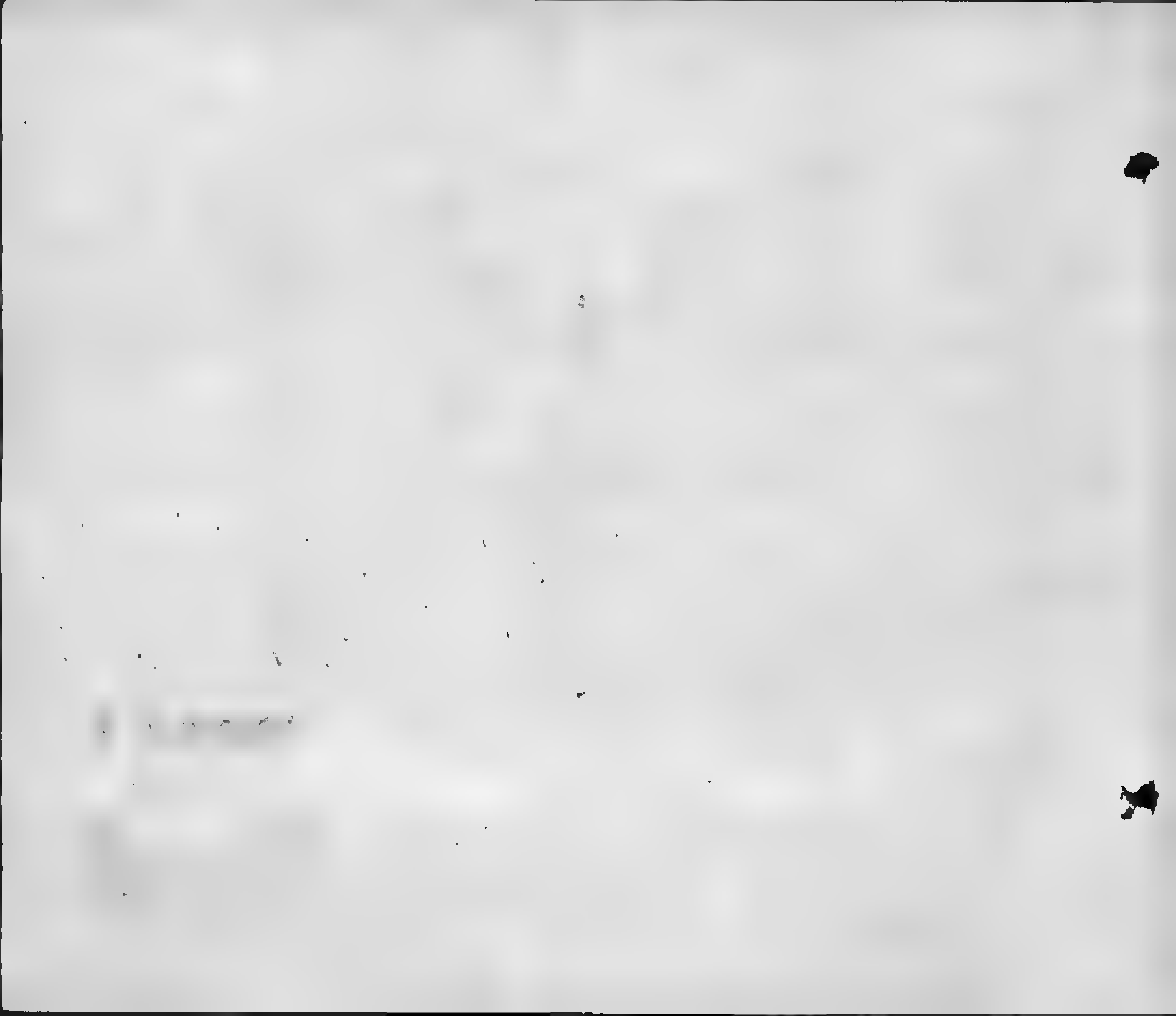
210

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07251
7237 Items 2,7, Film 184 7-25-55 et
CERTIFICATE OF DEATH Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN Pocomoke		LENGTH OF STAY (in this place) 8 Months		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pocomoke Stockton-Rural X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Belden Restorium				STREET ADDRESS Belden Restorium			
3. NAME OF DECEASED: (First) Alice		(Middle) M.		(Last) Tarr		4. DATE (Month) (Day) (Year) OF DEATH: July 17 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: November 18, 1876	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William J. Hancock				14. MOTHER'S MAIDEN NAME: Alice Bonnevillie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): NO		16. SOCIAL SECURITY NO.: None		17. INFORMANT & ADDRESS: Lester N. Lang, Pocomoke, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
159X IMMEDIATE CAUSE (A) Hemorrhage, Upper D-I, massive						minutes only	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Undetermined, Cause Acute - Poss. Mely Acute						Undet.	
(C) Cardiac Failure Grade 2						Several months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Obesity, Very marked approx 100 lbs, many months							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION: Tuberculosis, Pulmonary, arrested 2 years					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from December, 1952, to 17 July, 1953, that I last saw the deceased alive on 16 July, 1953, and that death occurred at 1:04 AM, from the causes and on the date stated above.							
SIGNATURE: N.E. Sartorius, Jr.		M. D. Pocomoke, Md.		DATE SIGNED: 18 July 55.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: July 20, 1955		NAME OF CEMETERY OR CREMATORY: M.E. Cemetery		LOCATION (City, town, or county) (State): Pocomoke, Md.	
DATE REC'D BY LOCAL REGISTRAR: July 19, 1955		REGISTRAR'S SIGNATURE: Anne E. White		24. FUNERAL DIRECTOR: Henry H. Watson		ADDRESS: Pocomoke, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



7239

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u> MARYLAND		CITY (If outside corporate limits, write RURAL OR TOWN <u>Accomack</u>)		STATE <u>Virginia</u> COUNTY <u>Accomack</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Means Va.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 Clark Ave</u>		LENGTH OF STAY (in this place) <u>7 months</u>		STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Sevell — Taylor</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>July 21 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec 25 1872</u>	9. AGE last birthday <u>82</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer Coun</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Calhoun</u>		17. INFORMANT & ADDRESS: <u>Mrs William E Ross</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>					
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE				(A) <u>Cerebral Hemorrhage</u> 2 days			
ANTECEDENT CAUSE (B):				(B) <u>Arteriosclerotic Cardio Vase</u> 4-6 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) <u>Senility</u> 16 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 1955</u> to <u>7/21, 1955</u> that I last saw the deceased alive on <u>7/21, 1955</u> and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Louis E. Howelyn, M.D.</u>		ADDRESS <u>Paranoke City</u>		DATE SIGNED <u>7/23/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bloxham Cem Bloxham, Accomack Va.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>July 24, 1955</u>		REGISTRAR'S SIGNATURE <u>Anne E White</u>		24. FUNERAL DIRECTOR <u>Henry G. Watson</u>		ADDRESS <u>Pocomoke Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-53

1

MARGIN RESERVED FOR BINDING

2

PLEASE TYPE OR TYPE IN PLAIN WITH TYPING TAP. Simply copy item of information as follows: 11- 111.

7251

CERTIFICATE OF DEATH

Reg. Dist. No. 35/...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WORCESTER</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>WORCESTER</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>NEWARK</u>				<u>NEWARK</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>ALINE DENNIS TOWNSEND</u>				<u>JULY 23 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>OCT. 25, 1878</u>	<u>76 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSE WIFE</u>		<u>OWN HOME</u>		<u>NEWARK MD</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>CLAYTON DENNIS</u>				<u>BETTY JONES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>217-65-7193</u>		<u>Mrs. HAZEL TAYLOR, NEWARK MD</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE				<u>2 DAYS</u>			
ANTECEDENT CAUSE (a)				<u>10 YRS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(b)							
(c)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <u>June</u> , 195 <u>2</u> , to <u>July 23, 1955</u> , that I last saw the deceased alive on <u>July 22</u> , 195 <u>5</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>John H. Laman</u>		<u>SNOW HILL</u>		<u>7-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7/25/55</u>		<u>BOWEN</u>		<u>NEWARK MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 25, 55</u>		<u>Clayton E. Cooper</u>		<u>Dr. De Burgh Berlin Md</u>			

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 16 1955

RECEIVED

7252

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
West Ocean City		15 yrs.		West Ocean City		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
At home				/			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
James Tynes				7 - 11 - 19 55			
5. SEX: Male		6. COLOR OR RACE: A.A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: About 1886	
9. AGE last birthday: About 69 yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. IF UNDER 5 HRS.	
		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer				10b. KIND OF BUSINESS OR INDUSTRY: Farming		11. BIRTHPLACE (State or foreign country): Smithfield, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME: Unknown			
14. MOTHER'S MAIDEN NAME: Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No			
16. SOCIAL SECURITY No.: None				17. INFORMANT & ADDRESS: Mrs. Nalia Mitchell, West Ocean City, Md.			
18. MEDICAL CERTIFICATION							
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
493X Immediate cause (a) Free woman							
Antecedent causes (s) (b) DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) DUE TO							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. Arterio sclerotic CVD with hypertension							
19a. DATE OF OPERATION: 0				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 5, 1955 , to July 11, 1955 , that I last saw the deceased alive on July 9, 1955 , and that death occurred at Bethesda from the causes and on the date stated above.							
SIGNATURE James Tynes		(Degree or title) MD		ADDRESS Ocean City, Md.		DATE SIGNED July 11, 1955	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Buried		7-12-55		Evergreen Cemetery		Berlin, Worcester Co., Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7-12-55		Helen F. Hayward		Mary A. Stewart		324 E. Church St., Salisbury, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Registered

Married

West Coast City

18 Dec.

Registered

West Coast City

At home

7 - 11 - 50

Times

Times

About 30

About 1000

Single

A.A.

Male

W.A.

Smithfield, Tennessee

Tennessee

Unknown

Unknown

Unknown

Mrs. Helen Hittner, West Coast City, Mo.

None

No

No

BUREAU X. 2

JUL 15 1955

RECEIVED

Office, November 10, 1955

Telephone Directory

7-11-55

Serial